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THE GOVERNMENT AND THE CITIZEN:

PARTNERS IN MENTAL HEALTH AND MENTAL RETARDATION

Keynote Address to

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by

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This is where I came in.

Five years ago, I had the honor of speaking at the first California Mental Health Awards banquet and here I am again at this, the Sixth Annual Governor's Award Program.

It reminds me of a time, during World War II, when I bumped into a Navy friend of mine after some months and noticed that he was sporting a couple of more gold stripes. When I congratulated him, he said, "Keep from getting shot long enough and you'll make it."

There have been days on Capitol Hill, during debates on mental health legislation, when I wasn't so sure I would make it. But here I am, five years older and in pretty good condition.

So is the new national mental health program.

I recently checked back on the things I said the night of the first banquet. It became immediately evident that in 1961, most of us, like psychiatrists, were concentrating on the "talking treatment."

At that time, our words were taking effect, but we had not achieved much action.

Let's think back to Thursday night, April 27, 1961.

One month earlier, the final report of the Joint Commission on Mental Illness and Health had been transmitted to the Congress and to the Governors of the several States. This in itself represented a great amount of effort and action, since the Joint Commiss had been authorized in 1955.

It took six hard years from the time of Congressional conception before anyone who chose to read that report could do so. And what they read, in this no-holds-barred report was:

> "The prevailing system with few exceptions has been to remove the acutely ill of mind far from the everyday scene -- to put them away in human dump heaps. How mental patients are treated typically depends on what socio-economic class they spring from and on what heap they land... Our information leads us to believe that more than half of the patients in most State hospitals receive no active treatment of any kind designed to improve their mental condition. This is the core problem and unfinished business of mental health."

The fact that the Joint Commission's final report was entitled "Action for Mental Health" has turned out to be prophetic. We are still and always will be called upon to keep our "talking treatment" going, in the interests of the mentally ill and the mentally retarded. But in the past five years, we have gotten plenty of action, too, and I am willing to state categorically that the years between 1961 and 1966 are only the beginning.

Let us take a few minutes to look at the score card.

Dr. Dan Blain, one of the first to talk about community-based treatment, was at that time Director of the California State Department of Mental Hygiene. He and Governor Brown immediately initiated action; the Governor's budget for 1961-1962 recognized the need for intensive treatment of mental illness in its early manifestations an in the community.

Then came John Fitzgerald Kennedy. His magnificent message to the 88th Congress in 1963 brought almost immediate action. President Kennedy spelled it out, loud and clear. He talked about human costs to the individual and dollar costs to the Nation. He recounted what we had and had not done. And then he asked the Congress to implement "a bold, new approach" in the treatment of mental illness and mental retardation.

As we well remember, the Congress answered in November of that year by adopting th Community Mental Health Centers Construction Act of 1963, of which Titles I and III provided funds in aid of construction of facilities for the mentally retarded and Title II authorized construction grants for community mental health centers.

Of course, we got our knuckles bloodied on that one, when we lost our battle to secure funds to support the staffing of centers. But we learned a lot in that defeat; we put what we learned into practice and in 1965, the amendments to the Centers Act provided for staffing funds.

While all this was going on, the Congress had also appropriated matching funds wit which the States began comprehensive planning to meet the mental health needs of their residents.

No one knew at the outset how this planning effort would turn out. California, wi its Long Range Plan for Mental Health Services, had again pointed the way. But even th plan was based on assumptions, in many instances, and hopes -- as well as facts.

What actually occurred in comprehensive planning was exciting; most of the State plans have been completed. They are as different as the topographies of the several States; but they have one thing in common: people.

More than 30,000 volunteers have served on mental health planning committees and task forces in the past two years. Physicians, educators, lawyers, clergymen, housewiv and civic minded citizens of all persuasions. And probably the most significant factor of their planning efforts is that they were planning in their own home communities and will be there to make the decisions that will put those plans into action.

It seems strange now that so many persons said we couldn't plan ahead for comprehe sive services and simultaneously work out State Plans for Centers, under which communit would be eligible for funds. But it is happening.

State Centers plans are being approved and centers construction grants are being awarded at an accelerated pace. To date, 27 state construction plans have been approve and many more are currently undergoing final review. Fifteen community mental health centers are in various stages of coming into being in all parts of the Nation.

The National Institute of Mental Health is adapting the regulations for eligibilit under the statute as flexibly as it possibly can to meet the needs of individual commur ties. But there are certain standards that must be maintained and communities must fir ways to solve the problems and secure Federal funds.

I am well aware that some communities dislike the requirement that a center must serve a population of 75,000 to 200,000 and not more. If a community mental health center were to serve a larger community, the whole intent of the statute would be defea

What we want are community centers providing in depth continuity of care, based or the needs of each individual. Any center serving a larger community would become the

victim of the same crowding, impersonalities and institutionalized treatment that characterize some of the large State mental hospitals. This is just what we are trying to correct. The NIMH staff has found that when communities really try to meet the terms of the statute, means can be devised and the service is planned more economically and more effectively.

You know, in reviewing events, the record shows that these have been three very yeasty years since 1963.

The Hospital Improvement Program and the Inservice Training Programs are upgrading care in mental hospitals and institutions for the mentally retarded at the same time th centers program develops.

By March 1, 200 mental hospitals and institutions for the retarded in 49 States and Territories had secured HIP grants, and inservice training programs are also expand The training courses do two things: first, they improve the skills of the nonprofessional hospital workers who provide most of the daily patient care. Second, they are beginning to train personnel in new jobs. This personnel, trained in modern methods, can serve as a core of workers in community mental health centers, as well as in the mental hospitals.

Many of the projects have concentrated on specialized problem areas which existing inadequate staffs have been unable to handle. For example, in the mental hospital fiel 23 projects support additional personnel to work with chronic and elderly patients; 12 provide desperately needed personnel to staff new units for children and adolescents; and four projects are helping to support specialized alcoholism treatment units which provide such services as individual and group psychotherapy, counselling for the famili

of alcoholics, vocational guidance and placement and work in conjunction with Alcoholic Anonymous.

In the field of mental retardation, 32 projects are concentrating on specialized services for the severely and profoundly retarded -- the most neglected of all of our people. One outstanding project conducted by a group of Southern States developed new techniques for training attendants in providing recreational activities for mentally retarded patients. The technical manual produced by this one modest project is now bei used by a number of schools for the retarded in various parts of the country.

Another trend toward expansion of prepaid insurance plans -- suggested early in th California master plan -- is beginning to provide coverage for mental illness, in more settings. This is still a problem on which citizens should press, but recent developme including the UAW contract, on the one hand, and the adoption of Medicare on the other, indicate that thousands upon thousands of additional consumers of health services -- including mental health services -- will now have money in their pockets to select heal services and to pay for them.

It is the major responsibility of the community, then, to see to it that the services are both available and accessible.

We can do this, if local communities actually accept the present situation. Feder funds are becoming available to communities in the health field in tremendous volume. Medicare is, of course, the largest. Under its provisions, psychiatric illness is covered -- not completely -- but these provisions are steps in the right direction.

During the first year of implementation of the Medicare legislation, it is estimat that about $200 million in additional Federal monies will be provided for better treatn

of the mentally ill. This figure does not include the large sums which will go into the Health Insurance Trust Fund for coverage of psychiatric hospitalization under Part of Title 18, nor does it include the additional state expenditures required as matchin funds for expanded coverage of the medically indigent and recipients of public assistance who require psychiatric care.

For the mentally retarded, under Medicare, authority is granted to implement Stat plans and there is new authority to train professional personnel for the multihandicap including retardates. As part of the 1965 staffing amendments to the Centers Act, expanded funds are appropriated to train teachers of the mentally retarded and the emotionally disturbed.

I told Dr. Wallace Babbington, of the President's Committee on Mental Retardation the other day that I was attending this conference and he said, "You can tell that tha in the field of mental retardation, we now have more programs, more interest, more public support and more administrative support than we have ever had."

President Johnson's Health Message, delivered to the Congress March 1, bears out that observation.

> "I intend to appoint a committee on mental retardation", said the President, "to assess our progress, to seek out new and better ways to cope with this terrible disability, and to recommend a long-range and comprehensive plan of action."

Earlier this month, the National Institute of Mental Health secured approval of i first major administrative and program reorganization in the 18 years of its existence a period during which its budget grew from $4 million in 1948 to $303 million starting July 1, 1966.

One of the significant results of this modern organization is that four study centers -- with authority to centralize research, demonstrations, consultations, in the field and to conduct programs and award grants, are being established.

These are centers for the study of the prevention, control and treatment of alcoho lism; suicide prevention; drug abuse; and mental health problems of metropolitan areas.

About five million people in the United States are alcoholics, affecting 20 millio family members. An estimated 200,000 new cases develop each year. According to a surv by the Industrial Division of the Menninger Foundation, alcoholism alone costs industry $2 billion a year. It has been estimated that alcoholism is a contributing factor in half of the auto fatalities in this country. In 1963, there were 1,500,000 arrests for drunkenness, and an additional 215,000 arrests for driving while intoxicated.

One out of every seven admissions to state and county mental hospitals is an alcoholic.

A recent study of cases of Aid to Families of Dependent Children found alcoholism as a major factor in 14% of the families receiving tax monies under this program.

Last year, because of a limitation of funds, the National Institute of Mental Heal spent less than $4 million in support of all research, training and demonstration progr in the field of alcoholism.

This is not to say that the NIMH is not moving in this area. Over the past four years it has supported the work of the Cooperative Commission on the Study of Alcoholis established through the joint efforts of the Institute and the North American Associati of Alcoholism programs. The report of the Commission is due later this year, and we ar confident that it will make landmark recommendations for improving preventive, treatmen and educational services. The Institute is also supporting the first nation-wide study of patterns of drinking in the general population.

Under the Title V demonstration program, the NIMH is addressing itself to the fact that 63% of general hospitals still do not admit alcoholics despite the clear and repea position of the American Medical Association that alcoholism is a sickness and not a criminal offense.

It is conservatively estimated that there are about 60,000 drug addicts in the country. They are responsible for a major percentage of crime in some of our larger cities.

One of the most serious problems in this field is re-addiction -- as high as 90% of those discharged from the Public Health Service hospital in Lexington become re-addicted to drugs shortly after their discharge. Title V grants in East Los Angeles ar in Brooklyn are supporting halfway houses as a resource to keep the addict from returni to the hospital. Another project supported over the last four years in the Washington Heights area of New York City is exploring the potential of a local public health agency in providing continual support for the newly discharged addict who is trying to gain a foothold in the community.

There are an estimated 20,000 suicides in this country each year, with leading students of the problem contending that the stigma surrounding it prevents full reporta and a much higher figure. There are approximately 200,000 suicide attempts a year.

Suicide is now the 10th leading cause of death in this country, and the third leac cause of death among college students and in the peacetime armed services.

Over the past six years, the NIMH has supported the pioneering work of the Los Angeles Suicide Prevention Center, the finest of its kind in the country. In addition, it has helped to support a few additional centers. But the fact remains that there ar

only 15 suicide prevention centers concentrated in eight states; I am informed that there are at least three dozen cities which would like to set up such centers.

The NIMH is now reviewing a plan -- developed by the Los Angeles center -- for a nation-wide chain of suicide prevention centers.

The Federal Government has committed itself to meeting the mental health problems in these areas head on; as the centers are developed, communities and States will benef directly.

The NIMH is also expanding its training programs, not merely in size, but in refinement to meet modern training needs. Physicians, other than psychiatrists, will be provided with more courses in psychiatry, to enable them to treat the minor mental disturbances as part of their regular practice.

The mental health professionals will be trained in new ways to do new jobs. Since there are not enough of them to go around, they must be trained as members of a team ir modern treatment techniques.

More medical schools will be encouraged to include training in community psychiatr and more physicians will be trained in community medicine.

Although these and other comparable efforts are highly commendable, I must in all candor admit that severe shortages of all kinds of psychiatric personnel are the most serious roadblock in our determined efforts to bring intensive psychiatric care to all who need it. Last year, close to four million Americans received treatment for mental illness in state hospitals, general hospitals, outpatient clinics and in the offices of private practitioners, but another two million were turned away because we lacked the treatment personnel to handle them.

Despite the fact that the National Institute of Mental Health has supported the training of 30,000 professionals in the four core disciplines -- psychiatry, psychology social work and nursing -- since 1948, we have never been able to catch up with the increasing demand for these people.

For example, approximately 25% of budgeted positions for staff psychiatrists in both state mental hospitals and schools for the mentally retarded still remain unfilled Many of the filled positions are held by foreign doctors -- in a number of states as high as 50% of the total psychiatric complement is made up of foreign born physicians. According to a recent survey published by the National Institute of Mental Health, 21 state hospitals are without a single psychiatrist, and 91 state hospitals have only one to four psychiatrists.

In "Psychiatric News", the monthly publication of the American Psychiatric Associa tion, an average of 150 positions for psychiatrists are offered each month. Some of these vacancies go unfilled for a year or more.

There is an increasing trend toward the opening of psychiatric units in general hospitals. Last year, a record number of 600,000 psychiatric patients were admitted to general hospitals. Despite this trend, a recent pilot study made by the NIMH staff disclosed that approximately half of the hospitalized patients in general hospitals have a primary or secondary diagnosis of mental illness, yet only 6% of all physicians and 3% of all nurses in these hospitals have had any psychiatric training.

The next few years will see a fantastic acceleration in the demand for psychiatric personnel.

The Medicare legislation, whose major provisions go into effect on July 1st of thi year, authorizes psychiatric services for people over 65 in general hospitals, state hospitals, and private institutions; it also provides, under Part B of Title 18 of the Social Security Act, for psychiatric out-patient services up to $250 a year for the mil of elderly people who have already elected to participate in this phase of the program.

Labor, through the bargaining process, is winning sizeable psychiatric benefits fc union members. For example, the contract negotiated by the United Auto Workers, which goes into effect on September 1st of this year, covers two and a half million workers and their dependents in 77 major cities for extensive inpatient care and up to $400 a year in outpatient psychiatric services.

However, the greatest demand for mental health professionals is already manifestir itself as new community mental health centers are built under the 1963 Kennedy legislat The announced goal of that legislation is 2,000 centers by 1975; this will generate a tremendous pressure for additional trained professionals in all disciplines.

A carefully documented 1965 NIMH survey indicates that we will need between 120,0(and 125,000 professionals in the four core disciplines by 1975. We have about 65,000 of these professionals now.

Federal support is one key to all these programs, but it is not the whole ball of wax. Health services in the United States of America, for the remainder of the twenti century will be provided only through a public-private partnership. This is not new. Our whole Federal system is based on this concept, but in the health field, fragmentati and jurisdictional jostling of various types have made that partnership less than maximally effective.

Many communities, at one and the same time resist outside -- or governmental-standards or other controls -- while at the same time doing their best to secure as many Federal dollars as possible.

This fratricidal strife can no longer be tolerated. The stakes are too high and the pot is too big. This game is for keeps, if we are to apply even the knowledge we already have to improve the mental and therefore the total health of the population of America.

The new community centers for mental health and mental retardation will contribute to this research, for it is obvious that, as we treat people at home, we will learn mor about how man behaves as he does, either in ordered or disordered fashion. We can then apply that knowledge both to treatment -- and some day -- to prevention.

From 1955 to 1963, we citizens were pleading, begging and haranguing legislators and Congressmen to provide Federal funds as a base to develop a national mental health program. That foundation has now been supplied.

Through a volunteer-government partnership, we can and are establishing treatment centers on that foundation. We must, at the same time, working with educators, welfare personnel -- and all the others who are trying to minimize the personal and environment health hazards of our frenetic and urbanized modern society -- learn to recognize the crisis before it occurs.

Our next crusade is with us. We must learn to curb mental disturbance before it hardens into chronicity. Instead of treating yesterday's breakdowns, we can build tomorrow's health.

To do it however, local communities must join with regional groups. Political jurisdictions must merge through contracts and other procedures to provide services for the actual health community in which the people reside, even when it crosses traditiona geographical boundaries.

The word "community" is the operative word. And the health community of interest must become the community of solution, through effective use of all the supports availa in the public-private partnership of 1966.

Californians must take the lead in achieving this partnership in actuality, just a this State has been among the leaders in past years.

I hope that your master plan of 1962 for mental health and mental retardation will soon be implemented.

Six mental health center projects have been approved; but you need one hundred centers, at least, to cover this vast State effectively.

The amendment of the Short-Doyle Act, providing for 75-25 State and local funding for augmented mental health services is an improved version of one of this country's pioneer community mental health service acts.

In mental retardation, California received the first community facility constructi grant. It was one of the first States to complete its comprehensive plan in mental retardation.

Two research centers in mental retardation are being constructed with Federal aid in California.

The new plan devised by the State Department of Mental Hygiene to regionalize Sta mental hospitals by assigning patients from a single geographic area to specific secti of the hospital seems a good stop-gap improvement of treatment as the centers develop.

The fact that the mental hospital population in California has declined each year since 1960 is a favorable sign. From a high of 37,489 patients resident in mental hospitals in 1959, the hospital population dropped to 30,183 in 1965.

But the problems still exist. A person voluntarily admitted to one of your State hospitals cannot be supplied with drugs and aftercare when he is discharged. On the one hand, we urge the mentally disturbed to seek help voluntarily, and with the other l we penalize them for it.

Commitment procedures themselves need to be improved in this State; I understand that Assemblyman Waldie heads a legislative investigation which will, hopefully, resul in improved legislation at the 1967 session.

As I said when I began, we've been getting some action. But let me remind you in conclusion that the Federal Government and the State government can and will help to implement plans for mental health services, but we citizens do the actual planning.

We are parts of both halves of that partnership, and don't forget it. Because in this Nation we citizens ARE the government. If we want these services badly enough we will get them. But we will <u>not</u> get them if members of the health community continue t compete selfishly with one another for the health dollar, either public <u>or</u> private.

We must complete our plans immediately, look at the funds available to all health services and agree on their proportionate allotment. And <u>that</u>, I submit to you, shoul keep us occupied for quite a time.